2008

Medical Plan

Information

ANNUAL SCHEDULE OF BENEFITS

MEDICAL PLAN

Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315
www.bluecrossmontana.com

New West Health Plan • 1-800-290-3657 or 457-2200
www.newwesthealth.com

Peak Health Plan • 1-866-368-7325
www.healthinfonetmt.com

MEDICAL RATES

Monthly Premiums	Traditional	Blue Choice	Peak	New West
Employee	$557	$466	$524	$444
Employee & spouse	$762	$630	$722	$618
Employee & children	$662	$550	$630	$538
Employee & family	$776	$642	$734	$628
Joint Core	$598	$498	$570	$488

MEDICAL PLAN COSTS

Annual Deductible
(Applies to all services, unless otherwise noted or a co-payment is indicated)

Coinsurance Percentages (% of allowed charges that the member pays)
General
Preferred Facility Services *(See page 35 & 36 for a list of preferred facilities)*
Nonpreferred Facility Services *(See page 35for a list of non-preferred facilities)*

Annual Out-of-Pocket Maximums*
(Maximum coinsurance paid in the year; excludes deductibles and copayments)

You pay deductible and coinsurance on allowable charges (see glossary on page 4).

MEDICAL PLAN SERVICES/COSTS

Hospital inpatient Services*

***Pre-certification of non-emergency hospitalization is strongly recommended & required by some plans - see plan descriptions**

Room Charges

Ancillary Services*

Surgical Services*

Hospital Outpatient and Surgical Center Services*

BENEFIT YEAR 2008

MEDICAL LIFETIME MAXIMUMS

Each Plan has a set maximum payable per person, per lifetime on the Plan. The amounts shown below are the amounts that the plan would pay per individual.

Traditional Plan: $2,000,000 lifetime maximum; Additional $2,000 available annually after the lifetime maximum is met.

Managed Care Plans: $2,000,000 lifetime maximum; Additional $2,000 available annually after the lifetime maximum is met.

TRADITIONAL PLAN Administered by BCBS of MT	MANAGED CARE BENEFIT PLANS BLUE CHOICE - Administered by Blue Cross/Blue Shield of MT NEW WEST - Administered by New West Health Plan PEAK - Administered by Peak Health Plan	
Benefits	**In-Network Benefits**	**Out-of-Network Benefits**
$550/Member $1,650/Family	$400/Member $800/Family	Separate $500/Member Separate $1,000/Family
25% 20% 35%	25%	35%
Average of $2,500/Member *(20% - 35% of $10,000 in allowable charges)* Average of $5,000/Family *(20% - 35% of $20,000 in allowable charges)*	$2,000/Member $4,000/Family	Separate $2,000/Member Separate $4,000/Family
Member Coinsurance:	**Member Coinsurance/Copayment:**	**Member Coinsurance:**
20% - 35%	25%	35%
20% - 35%	25%	35%
20% - 35%	25%	35%
20% - 35%	25%	35%
20% - 35%	25%	35%

ANNUAL SCHEDULE OF BENEFITS

MEDICAL PLAN SERVICES/COSTS

Physician/Professional Services (not listed elsewhere)

Office Visits

Inpatient Physician Services*

Lab/Ancillary/Miscellaneous Charges*

Emergency Services

Ambulance Services for Medical Emergency

Emergency Room *(If there is an emergency admission, see plan description for authorizing follow up care)*

Hospital Charges

Professional/Ancillary Charges

Urgent Care Services

Facility/Professional Charges

Ancillary - Lab & Diagnostic Charges

Maternity Services

Hospital Charges*

Physician Charges (including delivery, pre and post-natal office visits) and lab charges*

Ultrasounds*

Routine Newborn Care

Inpatient Hospital Charges

Preventive Services (see plan descriptions for what services are covered and when)

Adult Exams and Tests
Mammogram, gyno exam and pap, proctoscopic and colonoscopic exams, PSA tests, bone density tests

Adult Immunizations (such as Pneumonia and Flu)

Allergy Shots

Child Checkups and Immunizations

Mental Health Services

Inpatient Services*

Max: One inpatient day may be exchanged for two partial hospital days.

Outpatient Services

With EAP counselor referral

With NO EAP counselor referral

BENEFIT YEAR 2008

TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
25% (no deductible for first two non-routine office visits)	$15/visit (covers professional charges only)	35%
25%	25%	35%
25%	25% (no deductible on injectibles without an office visit)	35%
25%	$100 copay	$100 copay
20%-35%	$75/visit for facility charges only (waived if inpatient hospital or out-patient surgery coinsurance applies)	$75/visit for facility charges only (waived if inpatient hospital or out-patient surgery coinsurance applies)
25%	25%	25%
25%	$25/visit	$25/visit
25%	25%	35%
20% - 35%	25%	35%
25%	0% if member enrolls in prenatal program in first trimester of pregnancy; 25% without timely enrollment	35%
25%	25% (waived on first ultrasound if member enrolls in prenatal program as described above)	35%
20% - 35% (no deductible)	25% (no deductible)	35%
25% (no deductible) **Max**: 2 bone density tests/lifetime **Max**: $500 for colonoscopy, sigmoidoscopy, or proctoscopy	$15/visit (including specified labs) $0 (no deductible) for periodic mammograms 25% for periodic bone density scans, EKG sigmoidoscopies, double contrast barium, enemas, proctoscopies, & colonoscopies	35% (plan pays $75.00 toward mammograms - no deductible)
$50 Max (no deductible)	$15 with office visit 25% (no deductible) without office visit	35%
25% (no deductible)	$15 with office visit 25% (no deductible) without office visit	35%
25% (no deductible) 0% (no deductible for County Health Department through age 7)	$15/visit **Max**: Schedule recommended by US Department of Health & Human Services	35%
20% - 35% Max: 21 days *(No max for severe conditions)*	25% Max: 21 days *(No max for severe conditions)*	35% Max: 21 days *(No max for severe conditions)*
25% **Max**: 40 visits/yr *(No max for severe conditions)*	$15/visit **Max**: 30 visits/yr *(No max for severe conditions)*	35% **Max**: 30 visits/yr *(No max for severe conditions)*
50% **Max**: 20 visits/yr *(No max for severe conditions)*	$15/visit/yr **Max**: 30 visits *(No max for severe conditions)*	35% **Max**: 30 visits/yr *(No max for severe conditions)*

ANNUAL SCHEDULE OF BENEFITS

MEDICAL PLAN SERVICES/COSTS

Chemical Dependency Services

Inpatient Services*
(Inpatient services must be certified. Pre-certification is strongly recommended.)

Outpatient Services*

With EAP counselor referral

With NO EAP counselor referral

**Dollar max for all Chemical Dependency Services: Combined inpatient/outpatient max of $6,000/year; $12,000/lifetime; $2,000/year after max is met.

Rehabilitative Services - Physical, Occupational, Cardiac, Pulmonary, and Speech Therapy*

Inpatient Services*

Outpatient Services

Alternative Health Care Services

Acupuncture

Naturopathic

Chiropractic

Extended Care Services

Home Health Care*

Hospice*

Skilled Nursing*

Miscellaneous Services

Disease Process Education & Dietary/Nutritional Counseling

Durable Medical Equipment, Appliances, and Orthotics *(Prior authorization required for amounts >$1,000)*

PKU Supplies

Obesity Management* *(All plans require prior authorization)*

TMJ Treatment* *(All plans require prior authorization)*

Infertility Treatment* *(All plans require prior authorization)*

Bariatric Benefit* *(Requires prior authorization)*

Organ Transplants *(Must be certified. Pre-certification is strongly recommended.)*

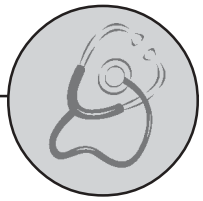
Transplant Services (including out-of-state travel)*

Lifetime Maximums:

BENEFIT YEAR 2008

TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
20% - 35% **Max:** Dollar Limit**	25% **Max:** Dollar Limit**	35% **Max:** Dollar Limit**
25% **Max**: 40 visits and Dollar Limit**	$15/visit **Max**: Dollar Limit**	35% **Max**: Dollar Limit**
50% **Max**: 20 visits and Dollar Limit**	$15/visit **Max**: Dollar Limit**	35% **Max**: Dollar Limit**
20% - 35% **Max**: 60 days/yr	25% **Max**: 60 days/yr	35% **Max**: 60 days/yr
20% - 35% **Max**: $2,000/yr for all outpatient ($10,000/year for prior-auth. conditions).	$15/visit **Max**: 30 visits/yr	35% **Max**: 30 visits/yr
25% (plus charges over $30/visit)	Not covered	Not covered
25% (plus charges over $30/visit)	Not covered	Not covered
25% (plus charges over $30/visit) **Max**: 25 visits in any combination	$15/visit **Max**: 20 visits/yr	35% **Max:** 20 visits/yr
25% **Max**: 70 days/yr	$15/visit **Max**: 30 visits/yr	35% **Max**: 30 visits/yr
25% (20%-35% if hospital-based) **Max**: 6 months	25% **Max**: 6 months	35% **Max**: 6 months
25% (20%-35% if hospital-based) **Max**: 70 days/yr	25% **Max**: 30 days/yr	35% **Max**: 30 days/yr
20% - 35% **Max**: $250/yr	0% (no deductible) **Max:** $250/yr	35% **Max:** $250/yr
25% **Max**: $100 for foot orthotics(per foot)	25% (Not applied to out-of-pocket max) **Max**: $100 for foot orthotics (per foot)	35% (not applied to out-of-pocket max) **Max**: $100 for foot orthotics (per foot)
25%	25% (no deductible)	35%
25%	25% non-surgical only	Not covered
25%	25% surgical only	Not covered
25% 1 in-vitro attempt per lifetime	25% Max: 3 artificial inseminations/lifetime	Not covered
25% **Lifetime Max:** $35,000	Not covered	Not covered
25% • Liver: $200,000 • Heart: $120,000 • Lung: $160,000 • Heart/Lung: $160,000 • Bone Marrow: $160,000 • Pancreas: $68,000 • Cornea/Kidney: No maximum	25% $500,000 lifetime maximum with $5,000 of the maximum available for travel to and from the facility.	Not covered

MEDICAL INSURANCE PLANS - 2008



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WHO IS ELIGIBLE?

Employees, spouses, domestic partners, and children are eligible for the Medical Insurance Plan. Enrollment is only allowed during these circumstances:

- within a new employee's initial 31-day enrollment period;
- within 63 days of a marriage, or court-ordered custody/legal guardianship);
- within 63 days after the automatic 31-day coverage (94 days) for births and adoptions.
- within 63 days of losing eligibility (not cancellation) for other group coverage;
- within 63 days of losing an employer's contribution toward other group coverage, sustaining a major increase in out-of-pocket costs, or losing benefits.

Notify your Agency Insurance Personnel when one of the above circumstances occurs (within the specified time-frames) to enroll dependents.

CLICK ON IT!

Learn more about your insurance administrator's customer service by visiting their web site at:

www.bluecrossmontana.com

www.newwesthealth.com

www.healthinfonetmt.com

INSTRUCTIONS

1. Read about each plan in the General Information section on this page.
2. Review and compare each plans' costs and services in the Annual Schedule of Benefits, starting on page 6.
3. Review your typical health care needs.
4. If you are considering a managed care plan, review the Managed Care Areas section on pages 32 through 34.
5. Determine which plan will work best for your family. Make your selection by completing the *2008 Employee Group Benefits Enrollment/Change* form.

2008 Employee Group Benefits Enrollment/ Change Form

GENERAL INFORMATION

The State of Montana offers an indemnity insurance plan and three managed care plans to choose from:

- **Traditional Indemnity Plan**
- **Blue Choice**
- **New West Health Plan**
- **Peak Health Plan**

TRADITIONAL PLAN

The Traditional Indemnity plan is administered by Blue Cross and Blue Shield of Montana (BCBS), which processes claims and payments, provides customer service and notice to members in the form of an Explanation of Benefits (EOB). BCBS also contracts with health care providers to offer plan members a provider network – providers who have agreed to accept certain plan allowances.

How The Plan Works

Plan members obtain medical services from a covered health care provider. If the provider is a BCBS provider, he or she will submit a claim for the plan member. BCBS will then process the claim and send an EOB to the plan member, indicating their payment responsibilities (deductible and/or coinsurance costs) to the provider. The Plan then pays the remaining allowable charges, which the provider accepts as full payment. **Please verify a provider is currently participating by calling BCBS or checking their website.**

If the provider is not a BCBS provider, you may be required to pay the entire fee and file a claim for reimbursement. There may be unallowed charges which you will have to pay.

Preferred Facility Services

Plan members may obtain covered medical services from any covered hospital. However, certain hospitals and surgical centers offer services for members on the Traditional plan that are subject to lower coinsurance rates. Please refer to the Participating Facilities section on page 35 for a list of these facilities. For your protection, it is strongly recommended you pre-certify all inpatient hospital services by calling your plan's customer service phone number, listed at the top of this page.

Out-of-State Services

The Blue Card Program lets plan members tap into BCBS plan networks in other states. If the out-of-state BCBS plan includes "hold harmless" provisions, the member will not be responsible for balances above the allowable amount.

MANAGED CARE PLANS

Blue Choice, New West, and Peak Health are managed care plans offered through the Montana Association of Health Care Purchasers, a purchasing pool of which the State is a member. The plans generally provide the same package of benefits, but there are differences in costs and participating providers.

How They Work

The benefits of managed care plans depend on the health care provider the member uses. When a network provider is used, the in-network benefits apply. When an out-of-network provider is used, out-of-network benefits apply (unless a required referral/authorization is obtained).

In-Network Benefits

Anytime a network provider is used whether the provider is a general practitioner, internist, or specialist, the in-network (highest level of benefit) is applied.

Check the plan's website for a complete listing of all in-network providers.

A referral/authorization is not required for in-network specialists. Referrals/authorizations are required to see an out-of-network specialist to receive the in-network level of benefits.

Out-of-Network Benefits

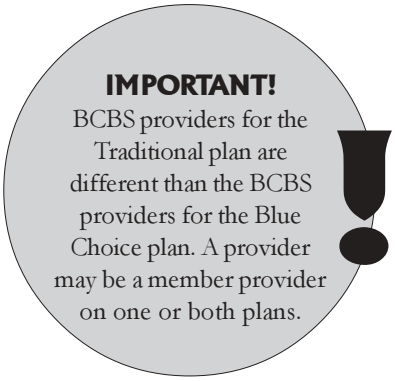
When plan members obtain services from providers who are not part of the plan's network, with no required referral/authorization, costs will be more because a separate and higher deductible, a higher coinsurance rate, and a separate out-of-pocket maximum apply.

Out-of-State Services

Plan members may receive in-network benefits for medical services in other states for a medical emergency. For non-emergency services out-of-state, please contact your plan administrator for specific provider network information.

SERVICE AREAS

The Traditional Plan is available to members living anywhere in Montana or throughout the world. The plan includes services of any covered providers. However, providers who are not BCBS member providers may charge more for a service than the plan allows, leaving you responsible for paying the difference.



The managed care plans – Blue Choice, New West Health Plan, and Peak Health Plan – are available to members living in certain areas in Montana. Please see pages 32-34 for a complete listing of covered zip codes for each plan.

Blue Choice

This plan is available in most of Western Montana and many other towns including Bozeman, Billings, Great Falls, and Havre.

New West Health Plan

This plan is available in most of Western Montana and many other towns including Bozeman, Billings, Great Falls, Havre, Libby, and Miles City.

Peak Health Plan

This plan is available to members in Billings, Butte, Deer Lodge, and nearby communities.

MEDICAL PLAN COST COMPARISONS

This cost comparison shows how each medical plan would process the same service and what costs the plan member would be responsible for paying. The example is **cumulative** with respect to deductibles and coinsurance. The first line of each example shows the total costs to the member. The next three lines show how that cost is divided between copays, costs applied to the deductible, and coinsurance costs. It does not include premium costs, which are outlined on page 6. These examples assume the services were for one member. This is simply an example for ease of plan comparison and is not a guarantee that similar services will process identically.

			TRADITIONAL	MANAGED CARE PLANS	
Sample Services	**Allowable Charge**			**In-Network**	**Out-of-Network**
Office visits 1, 2, & 3 ($50 each)	**$150**	**You pay ➡**	**$75**	**$45**	**$150**
Copay costs				$45 ($15/each)	
Costs applied to deductible			$50*		$150
Coinsurance costs			$25		
Lab charges with office visit 1	**$75**	**You pay ➡**	**$75**	**$75**	**$75**
Copay costs					
Costs applied to deductible			$75	$75	$75
Coinsurance costs					
Specialist Visit (i.e. dermatologist)	**$200**	**You pay ➡**	**$200**	**$15**	**$200**
Copay costs				$15	
Costs applied to deductible			$200		$200
Coinsurance costs					
Preferred hospital inpatient	**$8,500**	**You pay ➡**	**$1,880**	**$2,368.75**	**$3,023.75**
Copay costs					
Costs applied to deductible			$225	$325	$75
Coinsurance costs			$1,655	$2,043.75	$2,948.75
OR					
Nonpreferred hospital inpatient	**$8,500**	**You pay ➡**	**$3,121.25**	**N/A**	**N/A**
Copay costs					
Costs applied to deductible			$225		
Coinsurance costs			$2,896.25		

*First two office visits are exempt from the deductible for this comparison.